MEDICARE LEARNING NETWORK - COMPUTER/WEB-BASED TRAINING

MEDICARE SECONDARY PAYER

Welcome to the Medicare Secondary Payer training course!

Hello! My name is Cheryl Turner, and I work in the front office of a busy medical practice. It is my responsibility to screen patients for insurance coverage. During my time here I have learned a lot about Medicare.

In many instances, Medicare patients may have private health insurance that is primary to their Medicare coverage. When a Medicare patient has a primary insurance (primary payer), Medicare becomes their secondary payer only after the primary payer insurance company has been billed and the patient's claim has been processed.

This course will help you identify the various situations when Medicare is the secondary payer. When you have finished the course, you will have a greater understanding of the billing guidelines applicable to Medicare as the secondary payer.

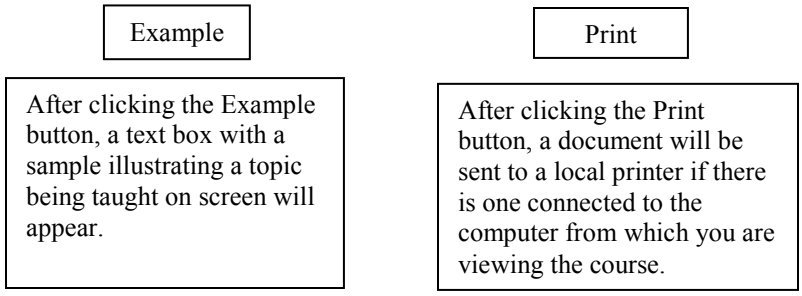
This course starts with a very brief preliminary knowledge assessment which will determine what you already know about the Medicare Secondary Payer (MSP) program.

After the pre-assessment, you will continue to the lesson menu.

More detailed information about Medicare can be obtained from the World of Medicare computer-based training course, or by calling your local Medicare contractor.

The entire course should only take you about 40 minutes to complete.

In addition to screen text and images used to present information, you will see an Example button and a Print button.



There may also be other images throughout the course that you can click for more information. Be sure to read the prompt line for instructions.

Preliminary Knowledge Assessment

You must begin with the Preliminary Knowledge Assessment to determine how much you already know about the Medicare Secondary Payer program.

This brief assessment asks you to answer a series of questions about the program. After you have answered all of the questions, assessment feedback is given to help you identify your level of comfort with the subject matter.

Access to the course is possible once the entire preliminary knowledge assessment has been completed.

! IMPORTANT !

Make sure you select an answer on each screen before clicking the Right Arrow button to continue. You are not allowed to go back to screens in the preliminary knowledge assessment and any screens without an answer selected will count as incorrect.

Preliminary Knowledge Assessment

Read the following statements:

A. When Medicare is the secondary payer, it is billed only after the primary payer is billed and processes the patient's claim.

B. Medicare Secondary Payer program pays any Medicare benefits that are not covered by the primary insurer.

Now select from the following:

- Statement A is true, statement B is false.
- Statement B is true, statement A is false.
- Both statements are true.
- Both statements are false.

To insure providers receive maximum reimbursement under the Medicare Secondary Payer program, it is important that all providers follow which guideline(s):

- File claims simultaneously to primary and secondary
- Validate patient eligibility on a regular basis
- Include all primary payer information when filing to secondary payer
- When in doubt about a patient's eligibility, always file to Medicare first.

The provider plays a major role in ensuring that the correct primary insurer is billed first. To make this determination, the provider has to identify all possible insurance coverage during the initial point of contact with the patient.

Which of the following methods could be used?

- Interviewing the patient
- Completing a patient questionnaire
- Contacting family members and/or employers
- All of the above

Of the various types of insurance that may be primary to Medicare, one covers the working aged. From the following descriptions, which individual(s) would qualify as working aged?

- Mrs. Rowland is 66 years old, married to a 45 year old man. She works full-time and is covered under her husband's employer group health plan (EGHP).

- Bob Feather is 70 years old and works part-time for a shipping company. He declined enrollment in his employer group health [EGHP] and has enrolled in Medicare as his primary payer.

- Edward Case injured his back on the job where he has been employed for over 25 years. He currently has medical coverage through his employer's group health plan [EGHP].

- Lloyd Packer, 69, injured his back while visiting his mother. Most of his treatment costs are covered by her liability insurance. He is not enrolled in his company's group health plan.

Dr. Able has been treating Anita Lopez for injuries she sustained in a car accident. Mrs. Lopez was not at fault in the accident. The doctor filed the claim with her auto insurance company.

In this situation, may Dr. Able file the claim with Medicare as primary payer?

- Yes, provided he withdraws the claim to the liability insurer.
- Yes, only the patient's no fault benefits have been exhausted.
- Yes, since Ms. Lopez is not at fault.

The Balanced Budget Act (BBA) of 1997 extended the 18-month coordination period to 30 months for Medicare entitlement for End Stage Renal Disease (ESRD).

Which of the following statements is true?

- Individuals who have not completed an 18-month coordination period after July 31, 1997 have an extension of the coordination period to 30 months under the BBA of 1997.
- Individuals who reach the 18-month point on or before July 31, 1997 do not qualify for the 30-month extension.
- Both statements are true.
- Both statements are false.

Sally Angelo is 63 and receives kidney dialysis treatment three times a week. Ms. Angelo still works part-time with a small company and is enrolled in their employer group health plan.

Is Medicare the secondary payer in this instance?

- Yes
- No

Colonel Mulligan, an 80-year-old veteran of World War II, chooses to go to a Medicare Part B provider that accepts Veterans Administration (VA) patients, instead of going to a VA facility.

Which of the following is correct?

- Medicare is always the primary payer when the patient is also entitled to VA benefits.
- Medicare is always secondary payer when the patient is also entitled to VA benefits.
- The Veterans Administration is the primary payer for VA patients.

Medicare does not make a secondary payment when a patient is covered by a Medicare designated HMO.

True or false?

- True
- False

Does Medicare make secondary payment for services processed and paid for by the United Mine Workers of America?

- Yes
- No

You scored ____ correct on the preliminary knowledge assessment.

1	2	3	4	5	6	7	8	9	10

It is strongly recommended that you proceed through all course lessons beginning with Lesson One to increase your understanding of the Medicare Secondary Payer program. The following lessons provide a detailed explanation of the program guidelines. You will find examples and printable job aids along the way that can assist your learning.

After completing the lessons, proceed to the Post-Course Knowledge Assessment to answer questions and receive your final score and course certification.

Introduction to Medicare Secondary Payer

After completing this lesson, you should be able to

- Explain Medicare Secondary Payer provisions

During patient registration, it is important for front office staff to identify whether a beneficiary's medical services should be covered by another insurance before, or in addition to, Medicare. This information helps providers determine whom to bill and how to file claims with Medicare.

This is not an easy task. There are MANY insurance benefits a patient could have, and many combinations of insurance coverage to consider, before determining who pays -- and when. Depending on the type of additional insurance coverage a patient has (if any), Medicare may be the primary payer for a patient's claim(s), or considered Medicare Secondary Payer (MSP).

A patient questionnaire will help you determine what types of insurance a patient may have.

Once a patient's insurance status is determined, you will also need to determine if the condition/injury currently being treated is eligible for coverage by Medicare as the primary payer, or by another insurer as the primary payer.

In the event Medicare is secondary payer, a claim must be billed to the primary insurer first. After the claim has been processed, then file the secondary claim to Medicare.

The Medicare Secondary Payer (MSP) program pays any Medicare benefits that are not covered by the primary insurer.

Let's look at the reasons why the MSP program is necessary…

<u>Why is Medicare Secondary Payer necessary?</u>

Before the Medicare Secondary Payer program was enacted (1980), Medicare usually assumed a position of primary payer for all Medicare beneficiaries, whether or not they were insured elsewhere.

Since the program's inception, a series of federal laws has changed the coordination of benefits between Medicare and other insurance.

These laws require that:

- Certain employer's (and other) insurance pay as the primary insurer; and
- Primary payment determination be based on all available insurance the patient may have.

Has the MSP program been successful?

Yes! The program has proved beneficial for:

- Medicare: requiring claims to be processed by insurers that are primary to Medicare has resulted in savings in excess of $6 billion annually.
- The provider: in most instances, primary insurers pay the provider more favorable payment rates than Medicare.
- The patient: in many cases, multiple insurance coverage reduces the amount a patient pays for services.
- The taxpayer, whose investment ensures Medicare program benefits well into the future.

What are the penalties for non-compliance?

First, let's look at some examples of non-compliance:

Failure to indicate on a Medicare claim if a patient is covered by a primary insurer

Penalty: No Medicare payment will be made.

Knowingly, willfully, and repeatably providing inaccurate information relating to the availability of other benefit plans.

Penalty: Up to $2,000 in civil penalties for each occurrence.

Failure on the part of insurers to pay primary to Medicare

Penalty: Double damages!

In the event Medicare is secondary payer, when is it billed?

- As soon as it is determined that Medicare is secondary payer.
- Before the primary insurer has been billed.
- After the primary insurer has been billed.

The MSP program includes a series of federal laws that require:

- Persons register with the MSP program as soon as they reach age 65.
- Providers register with the MSP program for each Medicare beneficiary they treat.
- Certain employer's and other insurance pay as the primary payer.
- Primary payment determination must be based on all available insurance the patient may have.

What happens if the provider knowingly and willingly does not acknowledge on a claim whether a beneficiary is covered by other insurance coverage?

- He can face up to $2,000 in penalties.
- His claim won't get paid.

When Medicare is Secondary Payer

After completing this lesson, you should be able to:

- Determine situations where Medicare is primary payer.
- Determine situations where Medicare is secondary payer.

When a beneficiary has a Medigap policy, or Medicaid coverage, Medicare is clearly the primary payer.

However, when a Medicare beneficiary has …

- Another insurance policy,
- Benefits under another federal insurance program, or
- A condition or injury where a third party may be liable for medical services,

… it is the provider's responsibility to help determine whether Medicare is the primary or secondary payer of services for a claim.

There are some situations where Medicare is the primary payer and some where Medicare is usually the secondary payer. There are also situations where Medicare is never primary or secondary.

Medicare is the Secondary Payer when beneficiaries are:

- ✓ Treated for an injury caused by a car accident where no fault auto insurance will cover the medical expenses
- ✓ Treated or diagnosed with a condition or injury that is due to the fault of another party, and will most likely be covered by a liability insurer
- ✓ Covered under their own, or a spouse's, Employer Group Health Plan [EGHP]
- ✓ Working disabled with coverage under a Large Group Health Plan [LGHP]
- ✓ Afflicted with End Stage Renal Disease [ESRD] and within the 30-month coordination period.

The following chart demonstrates when Medicare is a primary or secondary payer for beneficiaries in a variety of coverage situations and medical care needs.

Patient Situation:	Medicare as Primary:	Medicare as Secondary:
No other insurance	X	
Medigap supplemental insurance	X	
Medicaid coverage in addition	X	
Employer Group Health Plan [EGHP]*		X
End Stage Renal Disease [ESRD] In 30-month coordination period**		X
Disability		
Not working/unemployed	X	
Employed with LGHP*** coverage		X
With ESRD [see ESRD above]		
Condition/injury due to accident where there is …		
No fault [e.g., auto] insurance coverage		X
Liability [e.g., home owners, commercial, malpractice, auto, etc.] coverage		X
Worker's Compensation [see note below]		

*	An Employer Group Health Plan [EGHP] is a health insurance plan sponsored by either a patient's or the spouse of a patient's employer where a single employer of 20 or more employees is the sponsor and/or contributor to the EGHP, or two or more employers are sponsors and/or contributors and at least one of them has 20 or more employees.
**	The entitlement of Medicare benefits for an ESRD patient begins with a 30-month coordination period. During that period, Medicare is secondary payer to the patient's private insurance or private funds. Medicare remains the secondary payer throughout the entire 30-month coordination period even if the beneficiary becomes eligible for Medicare coverage duet o age or disability status. Further information about ESRD is available later in this lesson.
***	A Large Group Health Plan [LGHP] is a health insurance plan which is contributed to by an employer or employee organization having 100 or more employees, or a plan having at least one member which has at least 100 employees.

In addition to the Medicare as primary and Medicare as secondary situations you just learned about, there are other situations where you need to determine Medicare's role as primary or secondary payer.

Some other situations or programs that affect how and when a Medicare claim should be filed are shown below.

Worker's Compensation
Medicare does not make secondary payment if conditions or injuries are covered by Worker's Compensation. If a claim, or a portion of a claim, is denied by Worker's Compensation, a claim can be filed with Medicare Secondary Payer for consideration of payment on a primary basis.

Black Lung Program
Medicare does not pay secondary to services related to the Black Lung program. However, if a Medicare-eligible patient has a condition or injury not related to Black Lung, a claim can be filed to Medicare as the primary payer.

United Mine Workers of America (UMWA)
Those covered by UMWA are *never* covered by Medicare (as either primary or secondary). UMWA takes the place of Medicare.

We've established that it is the provider's responsibility to ensure that the correct primary insurer is billed first. How do we do this?

There are three ways to identify all available insurers by which a beneficiary may be covered:

- By interviewing the patient and asking appropriate questions.
- By completing a patient questionnaire.
- By contacting family members or employers.

Using these methods will help you

- Recognize situations and conditions that may involve a primary insurer.
- Recognize electronic filers who may have on-line patient eligibility.

George Carroll is a veteran, being treated in a Veterans Administration facility.

Would Medicare be considered the primary or secondary payer?

- Primary payer
- Secondary payer

Under which of the following coverages would Medicare be considered the primary payer?

- Medicaid
- Workmen's Compensation
- Medigap
- All of the above

Insurance Usually Excluded from MSP

As we discovered earlier, there are three programs under which payment for services is usually excluded from both primary and secondary Medicare benefits.

- Veterans Administration (VA) Benefits
- Worker's Compensation Benefits
- Black Lung Benefits

We'll take a look at each one …

<u>Veterans Administration (VA) Benefits</u>

Medicare does not pay for military veterans. Services for veterans are payable by the Veterans Administration.

Worker's Compensation Benefits

Medicare does not make secondary payment for services covered by Worker's Compensation. However if a claim, or a portion of a claim, is denied by Worker's Compensation, a claim can be filed with Medicare for payment consideration on a primary payer basis.

Payment for services provided to patients eligible for Worker's Compensation benefits should be filed with the employer's Worker's Compensation agency.

Black Lung Benefits

Medicare does not pay for services when services are payable by the Federal Black Lung Program. However, if the patient is treated for a condition not related to black lung, the claim is filed with Medicare as the primary payer.

All payments for services related to Black Lung should be mailed to:

The Federal Black Lung Program
P.O. Box 828
Lanham-Seabrook, MD 20703-0828

Insurance Unrelated to MSP

Secondary payment by Medicare is not made when:

- The patient is covered by a Medical Health Maintenance Organization (HMO) when the HMO replaces traditional Medicare.

- The patient belongs to the United Mine Workers of America (UMWA), claims should be sent to the UMWA, P.O. Box 9224, Van Nuys, CA 91409.

Grover Powell is covered by Worker's Compensation benefits for injuries he received as a messenger for the Transport Authority. The Transport Authority has been submitting claims for his treatments to the Worker's Compensation insurer, but some claims have been denied.

The Transport Authority decided to submit the denied claims to Medicare in the belief that Medicare would be the secondary payer. Are they correct?

- Yes

- No

Types of Insurance

After completing this lesson, you should be able to:

- Identify the different types of insurance
- Determine when other insurance may be primary

In addition to the insurance coverages discussed in the previous section, the following types of insurance coverage are, in most cases, considered primary payers (Medicare would be the secondary payer).

They are:

- No-fault (such as automobile insurance)
- Liability insurance (such as homeowners, commercial, malpractice, and automobile)
- Working aged (covered by group health plans)
- End Stage Renal Disease (ESRD)
- Disability

Let's take a closer look at each of the five …

No-fault Insurance:

No-fault insurance covers accident injuries and pays for medical expenses, no matter who is responsible for the accident.

Medicare is not the primary insurer for medical services covered by no-fault insurance.

Medicare is the primary insurer if the entire primary insurer allowance on the auto insurance claim is applied to the deductible, regardless of the amount of the deductible.

Liability insurance:

Liability insurance is responsible for paying for someone else's injury or property damage. Click the cabinet to view choices the provider may take in liability situations.

Bill insurer:

The provider can bill the liability insurer directly. If it is determined that the primary payer will not pay promptly [within 120 days after billing the liability insurer], the provider may file a claim with Medicare for conditional primary payment. If a Medicare conditional payment is made, the provider or supplier may not bill the primary insurer, nor place a lien against the beneficiary's insurance settlement for Medicare covered services. They may only bill the beneficiary for applicable Medicare deductibles and coinsurance.

File a Lien:

The provider can file a claim (lien) against the settlement proceeds in a liability case. If this option is selected, and it is determined that payment will not be made promptly (within 120 days), the provider may file a claim with Medicare for conditional primary payment. If a Medicare conditional payment is made, the provider or supplier may no longer bill the primary insurer, nor place a lien against the beneficiary's insurance settlement for Medicare-covered services. They may only bill the beneficiary for applicable Medicare deductibles and coinsurance.

Bill Medicare:

If it is determined that payment will not be made promptly (within 120 days), the provider may file a claim with Medicare for conditional primary payment. If a Medicare conditional payment is made, the provider or supplier may no longer bill the primary insurer, nor place a lien against the beneficiary's insurance settlement for Medicare covered services. They may only bill the beneficiary for applicable Medicare deductibles and coinsurance. Medicare intended these conditional payments as a means to avoid imposing a financial hardship on the patient.

Providers need to be aware of a couple of issues regarding requests for conditional payments.

Providers should never bill both Medicare and a liability insurer at the same time. This is double billing,, and is in violation of Medicare participation agreements.

Providers need to be aware of the following when filing requests for conditional payment from Medicare:

- First, providers cannot be reimbursed for any additional payment from the settlement after the case is closed.

- Second, providers cannot refund Medicare's primary conditional payment to Medicare and then accept the liability settlement.

Working Aged

What does the term, "working aged", mean?

Working aged means that a person is:

- Aged 65 or older,

And

- Working, with coverage provided by an employer's Employer Group Health Plan (EGHP), or not working, but covered by a working spouse's EGHP.

Medicare is the secondary insurer to an employer group health plan (EGHP) for the working aged:

When a single employer of 20 or more is the sponsor and/or contributor, or

When two or more employers are sponsors and/or contributors and at least one of them employs 20 or more persons.

The employee or spouse may reject EGHP coverage and elect Medicare as their primary payer. However, if coverage under the plan is rejected, the plan may not then offer or subsidize another plan intended only to supplement Medicare's benefits. By the same token, the employer may not purchase or subsidize an individual's supplement policy for the employee or family member.

End Stage Renal Disease

If a Medicare beneficiary receives an entitlement because he or she has End Stage Renal Disease, or ESRD, a coordination period begins, the length of which is dependent on the date of the entitlement.

Before enactment of the Balanced Budget Act (BBA) of 1997, individuals with ESRD were given an 18-month coordination period. That has now been extended to 30 months.

Under this new law, persons with ESRD who have not completed their 18-month coordination period after July 31, 1997, now have a 30-month coordination period.

If, on the other hand, the ESRD patient has reached the end of their 18-month period on or before July 31, 1997, they are bound by the 18-month timeframe.

Coordination period for ESRD patients:

- During the coordination period, Medicare is the secondary payer for those individuals who are:

- Diagnosed with ESRD and are covered under an employer group health plan (EGHP)

Dependent upon an individual diagnosed with ESRD and are covered under a family member's group health plan.

Medicare continues as the secondary payer throughout the coordination period, even if the beneficiary becomes entitled to Medicare for reasons of disability or age before the coordination period ends.

A coordination period starts for an aged or disabled beneficiary if the ESRD provisions start.

Disability Insurance

Since January 1, 1987, Medicare has been the secondary payer for:

- Individuals under 65 years of age who receive Medicare benefits for disability reasons (other than those with ESRD),

- And are covered under a Large Group Health Plan (LGHP).

What is a Large Group Health Plan?

- A health insurance plan to which an employer or employee organization of 100 or more contribute.

- A health insurance plan having at least one member with a minimum of 100 employees.

Just like the working aged, disabled Medicare beneficiaries may choose to reject the plan's coverage. If they do, Medicare becomes their primary payer and, from that point on, the employer's plan may not offer any supplemental coverage that is intended only to supplement Medicare's benefits.

This applies to active employees.

Is the following statement true or false?

Medicare is primary to no-fault insurance if it is determined that the beneficiary was not at fault for the accident.

- True
- False

In order to a Medicare beneficiary to be classified as "working aged", he or she must:

- Be diagnosed with ESRD
- Be age 65 years or older
- Be covered by an EGHP
- Be at least partially disabled

Peter Javitz has ESRD, with an entitlement date of January 1, 1997. When does his coordination period end?

- July 31, 1997
- January 1, 1998
- July 1, 1999
- June 30, 1999

Genna Corbin, a disabled Medicare beneficiary, has elected coverage under her husband's LGHP. Does she forfeit the Medicare Secondary Payer benefit?

- Yes
- No

Collecting Insurance Information

After completing this lesson, you should be able to:

- Identify various methods necessary to determine whether a beneficiary is covered by a primary insurer.

Medicare Requirements

For Medicare programs to work effectively, patient registration staff have a significant responsibility for the collection and permanent maintenance of patient information. They must ask questions to secure employment and insurance information.

They have a particular responsibility to identify primary payers other than Medicare so that incorrect billing and overpayments are minimized. For every admission or patient encounter, admitting staff must determine if Medicare is primary or secondary payer. The beneficiary must be queried about possible other coverage that may be primary to Medicare.

Earlier in this course, we learned that savings as high as $6 billion annually can be realized when claims processing includes accurate information about other insurance coverage.

In fact, failure to maintain a system of identifying other payers is viewed as a violation of the provider agreement with Medicare -- a serious breach of trust.

Maintenance of up-to-date insurance information is essential when filing a claim with Medicare or with a primary payer.

Development Letter

A Medicare Development Letter is sent to a provider or patient when a claim is filed that needs additional information or documentation.

Development letters usually detail the information necessary for Medicare to resume processing on a specific claim or claims. You may be responsible for gathering and sending the information that Medicare requests.

- Also note that there is usually a time limit placed on return of the requested information. If the additional information is not sent to Medicare within the timeframe specified in the Development Letter, payment of the claim will be denied by Medicare.

With Medicare Secondary Payer claims, Medicare contractors use certain development letters to help determine the insurer responsible for the benefits and/or appropriate payment. The following list contains commonly used development letters which ensure that Medicare pays only what it is obligated to pay:

- Initial Enrollment Questionnaire
- IRS, SSA and HCFA Data Match
- First Claim Development (FCD)
- Trauma Code Development (TCD)
- Receipt of claims with other insurers' explanation of benefits

Confirmation of Benefits

How does Medicare confirm its status as secondary payer?

Well, we have already established that it relies heavily on the information recorded when the patient was first interviewed.

But, in addition to your input, Medicare can refer to records maintained by:

- The Social Security Administration,

And by

- Other insurance companies.

Remember from the previous lesson that the patient may choose Medicare instead of an employer's group health plan as the primary payer?

If that choice is made, it must be confirmed in a letter from the employer, and the letter must include the date of disenrollment from the group plan.

In a situation where the patient retires, only the retired date is necessary.

Sometimes information the Social Security Administration (SSA) has on file about a patient's current insurance coverage is incorrect. To remedy this, the patient may call the SSA 1-800-772-1213 and request that the file be updated.

To help the beneficiary update the Medicare file, you should provide a questionnaire for the patient to complete before *you* place the call to Medicare to update their records.

Make sure the patient is available when you make the call because the Medicare representative will need the patient's authorization before updating the record.

Some information may not be accepted over the phone. In such cases, you will be instructed to submit written documentation when needed.

Use the following MSP questionnaire to ensure that Medicare is the primary payer and to ensure that the claim is complete and accurate. Click the print button for a copy of the questionnaire instructions.

The following chart, which consists of "6" parts, lists questions to ask Medicare beneficiaries upon each inpatient and outpatient admission. Use this chart as a guide to help identify other payers which may be primary to Medicare. Beginning with Part 1, ask the patient each question in sequence. Comply with any instructions which follow an answer. If the instructions direct you to go to another part, have the patient answer, in sequence, each question under the new part.

NOTE: This may be situations where more than one insurer is primary to Medicare (e.g., Black Lung and GHP). Be sure to identify all possible insurers.

Part 1

1. Are you receiving Black Lung (BL) Benefits?

   ___ yes; Date benefits began: CCYY/MM/DD

   BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL

   ___ no.

2. Are the services to be paid by a government program such as a research grant?

3. Has the Department of Veteran Affairs (DVA) authorized and agreed to pay for care at this facility?

   ___ yes; DVA IS PRIMARY FOR THESE SERVICES.
   ___ no.

4. Was the illness/injury due to a work-related accident/condition?

___ yes; Date of injury/illness: CCYY/MM/DD

Name and address of WC plan:

_____
_____
_____

Policy or identification number:
Name and address of WC plan:

_____
_____
_____

WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS. GO TO PART III.

___ no. GO TO PART II.

Part II

1. Was illness/injury due to a non-work-related accident?

___ yes. Date of accident: CCYY/MM/DD
___ no. GO TO PART III.

2. What type of accident caused the illness/injury?

___ automobile
___ non-automobile

Name and address of no-fault or liability insurer:

_____
_____
_____

Insurance claim number:

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

____ other.

3. Was another party responsible for this accident?

___ yes;

_____
_____
_____

Insurance claim number:

LIABILITY INSURER IS PRIMARY ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

___ no. GO TO PART III.

Part III

1. Are you entitled to Medicare based on:

___ Age. Go to Part IV.
___ Disability. Go to Part V.
___ ESRD. Go to Part VI.

Part IV - Age

1. Are you currently employed?

___ yes;

Name and address of your employer:

_____
_____
_____

___ no. Date of retirement: CCYY/MM/DD

2. Is your spouse currently employed?

___ yes;

Name and address of spouse's employer:

_____
_____
_____

___ no. Date of retirement: CCYY/MM/DD

IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II. DO NOT PROCEED ANY FURTHER.

3. Do You have group health plan (GHP) coverage based on your own, or a spouse's, current employment?

___ yes;
___ no. STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.

4. Does the employer that sponsors your GHP employ 20 or more employees?

___ yes. STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.

Name and address of GHP:

_____
_____
_____

Policy identification number:
Group identification number:
Name of policy holder:
Relationship to patient:

___ no. STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.

Part V - Disability

1. Are you currently employed?

   ___ yes;

   Name and address of your employer:

   _____
   _____
   _____

   ___ no. Date of retirement: CCYY/MM/DD

2. Is a family member currently employed?

   ___ yes;

   Name and address of employer:

   _____
   _____
   _____

   ___ no.

IF THE PATIENT ANSWERS NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II. DO NOT PROCEED ANY FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a family member's, current employment?

   ___ yes;
   ___ no. STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.

4. Does the employer that sponsors your GHP, employ 100 or more employees?

   ___ yes. STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.

   Name and address of GHP:

   _____
   _____
   _____

Policy identification number:
Group identification number:
Name of policy holder:
Relationship to the patient:

___ no. STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.

PART VI - ESRD

1. Do you have group health plan (GHP) coverage?

   ___ yes;

   Name and address of GHP:

   _____
   _____
   _____

   Policy identification number:
   Group identification number:
   Name of policy holder:
   Relationship to the patient:

   Name and address of employer, if any, from which you receive GHP coverage:

   Name and address of GHP:

   _____
   _____
   _____

   ___ no. STOP. MEDICARE IS PRIMARY.

2. Have you received a kidney transplant?

   ___ yes; Date of transplant: CCYY/MM/DD
   ___ no.

3. Have you received maintenance dialysis treatments?

   ___ yes. Date dialysis began: CCYY/MM/DD

   If you participated in a self dialysis training program, provide date training started: CCYY/MM/DD

   ___ no.

4. Are you within the 30-month coordination period?

   ___ yes.
   ___ no. STOP. MEDICARE IS PRIMARY.

5. Are you entitled on the basis of either ESRD and age or ESRD and disability?

   ___ yes;
   ___ no. STOP. GHP IS PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.

6. Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?

   ___ Yes; STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.

   ___ No. INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.

7. Does the working aged or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)?

   ___ Yes; GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.

   ___ No; MEDICARE CONTINUES TO PAY PRIMARY.

FAILURE TO OBTAIN THE INFORMATION LISTED IN THESE SECTIONS IS A VIOLATION OF YOUR PROVIDER AGREEMENT WITH MEDICARE. THE INFORMATION YOU MUST OBTAIN IS ESSENTIAL TO FILING A PROPER CLAIM WITH MEDICARE OR A PRIMARY PAYER. FAILURE TO FILE A PROPER CLAIM CAN RESULT IN THE UNNECESSARY DENIAL OR DEVELOPMENT OF CLAIMS.

Collecting Insurance Information

Which means are used to determine if Medicare is primary or secondary payer?

- Questioning the beneficiary during each admission.
- The beneficiary's Social Security records.
- Development letters.
- The beneficiary's Internal Revenue Service records.

A Medicare development letter is sent to a provider or patient when a claim is filed that needs additional information or documentation.

- True
- False

A Medicare beneficiary has received treatment for a torn ligament. He is expected to recover completely from his injury but, in the meantime, has changed jobs and needs to update his Medicare coverage status with the new employer and EGHP insurance information.

You are able to assist him by giving him a questionnaire to complete before a call is placed to Medicare to update their files. He is eager to return to his new job, and asks you to place the call for him. He signs the completed questionnaire and returns to his job. Is this OK?

- Yes
- No

How to File a Secondary Claim to Medicare

After completing this lesson, you should be able to:

- Successfully file a claim to Medicare for secondary payment.

There are six steps to follow to successfully file a claim for Medicare secondary payment.

There is a lot to be gained from following these procedures --

- ✓ You save time by not having to repeat a job.
- ✓ Your patient is reimbursed promptly.
- ✓ Unnecessary costs are not incurred by Medicare

STEP ONE

When you've identified the patient's primary payer, complete the

HCFA 1450 (Medicare A) claim form, or

HCFA 1500 (Medicare B) claim form.

STEP TWO

Attach copies of the payment report, check, etc. -- once received from the primary insurance company -- to the Medicare claim form. Be sure the attached information includes the amounts allowed and paid by the primary insurer.

Here is a useful checklist --

- ✓ Provider's name or provider number
- ✓ Dates of service for each procedure
- ✓ Number of services billed
- ✓ Billed amount matching the primary payment sheet
- ✓ A legend that explains why a payment is denied and where a code for denial is included
- ✓ Amounts allowed and paid by the primary insurer

STEP THREE

- ✓ Make sure the claim matches the services billed on the primary payment sheet.
- ✓ For Medicare B claims, do not include independent laboratory services on the same claim as physician services.
- ✓ Also for Medicare B claims, do not indicate the amount paid by the primary payer as a patient paid amount in block 29 of HCFA 1500.

STEP FOUR

This step is necessary for electronic claims only.

- ✓ Contact your vendor to arrange for services to be filed electronically via the National Standard Format, or ANSI.
- ✓ Verify that all applicable fields have been completed.
- ✓ Access the Health Care Financing Administration web site for additional information at www.hcfa.gov.

STEP FIVE

- ✓ File Medicare Part A claims to …
    - The designated address or electronic transmission number for the Medicare intermediary that processes claims for your state.
- ✓ File Medicare Part B claims to …
    - The designated address or electronic transmission number for the Medicare carrier that processes claims for your state.

Is the following statement true or false?

Should you include in a Medicare secondary payer claim the amounts allowed and paid by the primary insurer?

- ✓ Yes
- ✓ No

Calculating Medicare Secondary Payments

After completing this lesson, you should be able to:

- Calculate the Medicare Secondary Payments for Medicare A and Medicare B claims

We know now that claims to Medicare secondary payer are submitted AFTER the original claim has been processed and settled (or denied) by the primary insurer.

And we know that the primary insurer in MSP situations includes No-fault, Liability, Working Aged, Disability, and ESRD coverage.

At this point, we will assume that you have prepared the claims, attached the paperwork.

Now, we'll take a look at how MSP calculates payments, and we'll present a few exercises.

Calculations for Medicare Part A

When determining the amount of Medicare payment for Medicare Part A, the Medicare secondary payment is the lowest of:

1. Total prospective payment amount minus the amount paid by the primary payer for Medicare covered services; or

2. Total prospective payment amount minus any applicable Medicare deductible and/or coinsurance amounts; or

3. Your billed charges (or the amount you are obligated to accept as payment in full when the primary payer pays a lesser amount) minus the amount paid by the primary payer for Medicare covered services; or

4. Your billed charges (or the amount you are obligated to accept as payment in full when the primary payer pays a lesser amount) minus any applicable Medicare deductible and/or coinsurance amounts.

Calculations for Medicare Part A

If the prospective amount is $4,000, the amount paid by the primary payer is $1,000, the deductible and coinsurance is $700, and the billed charges are $5,000, what would be the Medicare secondary payment?

1. $3,000

2. $3,300

3. $2,000

4. $4,300

Answer number one, $3,000, is correct. The total prospective payment minus any deductible or coinsurance. It is the LOWEST total of the four options listed on the previous page.

Calculations for Medicare Part B

In order to determine secondary payment, follow the steps below:

Determine Medicare's primary allowance (if Medicare were paying as the primary payer):

a) Medicare fee schedule allows = $150
b) Medicare deductible = $0
c) Subtotal = $150
d) Medicare payment at 80% = $120

Determine the MSP payment:

a) Amount from 1a = $120
b) Primary allowance = $170
c) Choose the higher of 2a or 2B = $170
d) Primary paid amount = $136
e) Remainder = $34
f) MSP payment would be = $34
g) Patient responsibility = $0

Calculations for Medicare Part B

Medicare fee schedule allows $500 for the services being billed and no deductible is due. The primary payer allowed $700 and paid $560. Which amount is the correct amount that Medicare would pay to you as the Medicare secondary payer?

1. $360
2. $700
3. $560
4. $140

Answer #4 is correct. The primary allowed amount ($700) was higher than the Medicare allowed amount ($500). Then subtracting the primary paid amount ($560) from the primary allowed amount ($700) leaves $140 Medicare secondary payment.

Using the information below, calculate the Medicare Part A secondary payment:

1) Prospective payment is $11,000; 2) Primary paid amount is $8,800; 3) Deductible/coinsurance is $0; 4) Billed charges equals $12,000.

- $12,000
- $3,200
- $2,200
- $11,000

Using the information below, calculate the Medicare Part B secondary payment.

1) Medicare's allowed amount is $200; 2) Primary allowed amount is $300; 3) Deductible/coinsurance is $0; 4) Primary paid amount equals $240

- $60
- $40
- $100
- $48

Post-Course Knowledge Assessment

Now it is time to take the Post-Course Knowledge Assessment to determine how much you have learned from this course about Medicare Secondary Payer.

You will be asked questions related to the content of this course. Please note that you will not be able to exit the assessment once you start it.

Assessment feedback is given after you have answered all questions, and will indicate those questions you answered incorrectly. The assessment feedback will also include the correct answers to the questions you missed.

When you reach the end, you will have the option to print your "Progress Report" which contains your preliminary and post-course knowledge assessment scores.

You may re-take the post-course knowledge assessment as often as you like.

Post-Course Knowledge Assessment

Why is an eligibility questionnaire important for Medicare patients to fill out?

- The answers help your office determine if the patient has any communicable diseases.
- The answers usually provide information about whom to contact in case of an emergency.
- The answers help your office determine if the patient is covered by any other medical insurance.

What type of insurance coverage does a beneficiary have if the insurance is provided as a benefit through her spouse's job?

- Medigap Coverage
- Employer Group Health Insurance
- Worker's Compensation

Based on the scenario below, would Medicare be the primary or secondary insurer?

Scenario: The patient injured himself falling down a flight of icy stairs at a friend's home. The friend owns the home and has homeowner's insurance.

- Primary insurer
- Secondary insurer

Sarah Javitz has ESRD, with an entitlement date of February 1, 1997. When does her coordination period end?

- February 1, 1999
- July 1, 1999
- July 31, 1999
- February 1, 1999

Using the information below, calculate the Medicare Part B secondary payment:

1) Medicare's allowed amount is $400; 2) Primary allowed amount is $500; 3) Deductible/coinsurance is $0; 4) Primary paid amount is $400.

- $400
- $250
- $100
- $80

Select the sources from which Medicare can obtain information to establish a patient's Medicare Secondary Payer status.

- The beneficiary.
- Other insurance companies.
- The Social Security Administration.
- All of the above.

What can a provider do to determine if a beneficiary is covered by an insurer that may be primary to Medicare?

- Request eligibility information from the Internal Revenue Service.
- Have the beneficiary complete an eligibility questionnaire.
- When in doubt, file the beneficiary's claim to Medicare for primary payment.
- Request eligibility information from the Health Care Financing Administration.

In order for a Medicare beneficiary to be classified as "working aged", she or he must:

- Be at least partially disabled.
- Be employed and covered by an EGHP.
- Be diagnosed with ESRD.
- Be unemployed and covered by EGHP.

Using the information below, calculate the Medicare Part A payment:

1) Prospective payment amount is $11,000; 2) Primary paid amount is $8,800; 3) Deductible/coinsurance is $0; 4) Billed charges equals $12,000.

- $2,200
- $3,200
- $11,000
- $12,000

In the event Medicare is secondary payer, when is it billed?

- After the primary insurer has been billed.
- Before the primary insurer has been billed.
- As soon as it is determined that Medicare is secondary.

You scored ___ correct on the post-course knowledge assessment.

Refer to the bar button below to see which questions you answered correctly or incorrectly. Click numbered button to view the correct response for each question. A green button indicates a correct answer. A red button indicates an incorrect answer.

1	2	3	4	5	6	7	8	9	10

Your course "Progress Report" containing both the Preliminary Knowledge Assessment and Post-Course Knowledge Assessment scores can be obtained by clicking the Print Button below. Front Office course certification is given to individuals scoring 90% or better on the post-course knowledge assessment.

Note: You may retake the post-course knowledge assessment at any time.

(End of Medicare Secondary Payer Section)

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